

THERMiva®

Patient Name: _____ Date: _____

Date Of Birth: _____

Pre-Treatment Questionnaire

Please rate your vaginal laxity:

Very
Loose

①

②

③

④

⑤

Very
Tight

Please rate your sexual satisfaction from vaginal intercourse:

Extremely
Dissatisfied

①

②

③

④

⑤

Extremely
Satisfied

Please rate your ability to climax/orgasm:

Never

①

②

③

④

⑤

Always

Please rate your vaginal moisture during sexual activity:

Very
Dry

①

②

③

④

⑤

Very
Moist

How would you rate your ability to control urine when you cough?

No
Control

①

②

③

④

⑤

Excellent
Control

How successful are you with controlling your stream of urine (start and stop)?

No
Control

①

②

③

④

⑤

Excellent
Control

How often do you feel urinary urgency (feeling that you have to go to the bathroom)?

No
Control

①

②

③

④

⑤

Excellent
Control

Please describe your present state of feminine health and wellness: